

<i>SERFF Tracking Number:</i>	<i>ARBB-127684374</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	<i>49941</i>
<i>Company Tracking Number:</i>	<i>23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>
<i>Product Name:</i>	<i>Amendments</i>		
<i>Project Name/Number:</i>	<i>General Amendments/23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12</i>		

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Amendments

SERFF Tr Num: ARBB-127684374 State: Arkansas

TOI: H16G Group Health - Major Medical

SERFF Status: Closed-Approved State Tr Num: 49941

Sub-TOI: H16G.001A Any Size Group - PPO

Co Tr Num: 23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert

Authors: Christi Kittler, Yvonne
McNaughton, Frank Sewall, Rita
Thatcher, Evelyn Laney

Disposition Date: 10/27/2011

Date Submitted: 10/04/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 11/28/2011

State Filing Description:

General Information

Project Name: General Amendments

Status of Filing in Domicile: Pending

Project Number: 23-2612,23-2613,23-2614 1/12,23-2564,23-2567
R1/12

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is state
of domicile.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 10/27/2011

State Status Changed: 10/27/2011

Deemer Date:

Created By: Evelyn Laney

Submitted By: Evelyn Laney

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

Enclosed please find duplicate copies of the above referenced forms for your review and approval if indicated. Also attached is a PPACA Uniform Compliance Summary as is required when filing PPACA forms.

We have amended the "Newborn Care in the Hospital" benefit for all groups with maternity benefits to clarify that coverage for a newborn is contingent on the Employee adding the newborn to the policy in accordance with Section 6.0.

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This is a clarification only and does not represent a benefit change.

Act 1042 of Arkansas' 88th General Assembly requires coverage for gastric pacemakers for individuals with gastroparesis. We have add a benefit for gastric pacemakers and also deleted the exclusion for gastric stimulators to comply with the new law.

We have also added a new benefit for pilot projects which may provide additional coverage depending on the pilot project we are conducting at the time.

We have added an exclusion for any provider that has been excluded from participation in any federally funded programs.

We have amended the Claim Processing and Appeals section to comply with the new federal requirements under Patient Protection and Affordable Care Act dealing with External Review as well as the Departments new External Review rule.

Autism amendment – Act 196 of Arkansas' 88th General Assembly requires coverage for autism spectrum disorder including applied behavior analysis. Therefore, we are adding a benefit for new groups and renewal groups effective October 1, 2011 to comply with the law. We are also deleting the exclusion for IDEA Covered Services in accordance with the Act.

We have amended the Preventive Health Services amendments (23-2594, 23-2597 R1/12) to allow coverage for services provided in an Outpatient Hospital or Ambulatory Surgery Center when such services cannot be performed in the office of a Primary Care Physician.”

Also attached is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d).

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the certificates/policies to which these amendments are attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
320 West Capitol, Ste 211 501-378-2165 [Phone]
Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

SERFF Tracking Number: ARBB-127684374 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? No
Fee Explanation: \$50.00 per form
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$250.00	10/04/2011	52443758

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/27/2011	10/27/2011
Approved	Donna Lambert	10/10/2011	10/10/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Amendment	Evelyn Laney	10/27/2011	10/27/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
23-2565	Note To Reviewer	Evelyn Laney	10/10/2011	10/10/2011
AMENDMENT NUMBER 23-2565	Note To Filer	Donna Lambert	10/06/2011	10/06/2011

SERFF Tracking Number: ARBB-127684374 *State:* Arkansas
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Disposition

Disposition Date: 10/27/2011

Implementation Date: 11/28/2011

Status: Approved

HHS Status: HHS Approved

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ARBB-127684374 State: Arkansas

Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 49941

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Form (revised)	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes

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Disposition

Disposition Date: 10/10/2011

Implementation Date: 11/10/2011

Status: Approved

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Form (revised)	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes
Form	Amendment	Approved	Yes

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Amendment Letter

Submitted Date: 10/27/2011

Comments:

We added an amendment to the Medication section as well as a provision to Glossary of Terms section in the group benefit certificate.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
23-2612 1/12	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment Initial					40.700	23-2612 1-1-12 Filing Version.pdf

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Note To Reviewer

Created By:

Evelyn Laney on 10/10/2011 08:28 AM

Last Edited By:

Donna Lambert

Submitted On:

10/19/2011 02:03 PM

Subject:

23-2565

Comments:

The PPACA form contained references to amendments that had previously been approved by your department. Please call me if you have any further questions. (501) 378-2165.

Thanks so much.

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Note To Filer

Created By:

Donna Lambert on 10/06/2011 03:24 PM

Last Edited By:

Donna Lambert

Submitted On:

10/19/2011 02:03 PM

Subject:

AMENDMENT NUMBER 23-2565

Comments:

The Compliance Summary refers to Amendment Number 23-2565. I do not see this form attached to the form schedule tab. Am I missing something?

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Project Name/Number: General Amendments/23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12

Form Schedule

Lead Form Number: 23-2612 1/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/27/2011	23-2612 1/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Initial		40.700	23-2612 1-1- 12 Filing Version.pdf
Approved 10/10/2011	22-2613 1/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Initial		40.700	23-2613 10- 1-11 Filing Version Autism Benefit.pdf
Approved 10/10/2011	23-2614 1/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Initial		40.700	23-2614 1-1- 12 Filing Version.pdf
Approved 10/10/2011	23-2564 R1/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Revised	Replaced Form #: 23-2564 R1/12 Previous Filing #: 23-2564 10/10	40.700	23-2564 R1- 12 Preventive Health Services OP Hospital rev cmk.pdf
Approved 10/10/2011	23-2567 R1/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Revised	Replaced Form #: 23-2567 R1/12 Previous Filing #: 23-2567 10/10	40.700	23-2567 R1- 12 Preventive Health Services OP Hospital rev cmk - CMM.pdf



**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
COMPREHENSIVE MAJOR MEDICAL
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2612
GENERAL AMENDMENT
Form Nos. 163,164,232,233,234,235,239,240,241,242,
243,244,245,246,263,265,266,267,268,269,270,271**

The following subsection amendments are effective on January 1, 2012.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Therapy Services, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Maternity," Subsection 3. is hereby amended to read as follows.

Newborn Care in the Hospital. Provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. An Employee or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services. ^{1]}

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Medications, Subsection c. is hereby amended to add the following new Subsection. All remaining Subsections are hereby re-numbered to correlate with the change.

Prescriptions, Excluded Providers. Prescriptions ordered or written by any Physician or Provider who is excluded from coverage under the Plan, are not covered. Prescriptions presented to or filled by any Pharmacy which is excluded from coverage under the Plan, are not covered. See Subsection 4.2^{2]}

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions" is hereby amended to add the following new Subsections.

Gastric Pacemaker Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate including the Deductible and Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from the Company. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.**

¹ Will not apply to groups without maternity coverage.

² Will not apply to groups without retail drug coverage.

Pilot Project Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, from time to time, the Company may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Benefit Certificate, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting the Company's website at WWW.ARKANSASBLUECROSS.COM or by calling Customer Service.

SPECIFIC PLAN EXCLUSIONS, Health Care Providers is hereby amended to add the following new Subsection. All remaining Subsections are re-numbered to correlate with the change.

Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Gastric Electrical Stimulators" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

CLAIM PROCESSING AND APPEALS, Claim Processing, "Explanation of Benefit Determination" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Documentation" Subsection b. is hereby amended to read as follows.

Appellant's Right to Information. The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

- i. were relied upon in making the benefit determination;
- ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- iii. demonstrate compliance with the terms of the Plan.; or
- iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Notification of Determination of Appeal to Plan" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review) "Claim Appeals Subject to External Review", is hereby amended to read as follows.

1. **Claim Appeals Subject to External Review.**
 - a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.

- b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:
 - i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or
 - ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or
 - iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or
 - iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.13) and you have simultaneously submitted an appeal to the Plan.
- 2. **Where and When to Submit External Review Appeal.** You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling 1-800-282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.3.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.
- 3. **Independent Review Organization and Independent Medical Reviewer**
 - a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.
 - b. **The Independent Review Organization** is not affiliated with, owned by or controlled by the Company. The Company pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.
 - c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an employee of the Company and does not provide services exclusively for the Company or for individuals holding insurance coverage with the Company. The Independent Medical Reviewer has no material financial, familial or professional relationship with the Company, with the Plan Administrator, with an officer or director of the Company or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.
- 4. **Documentation**
 - a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may

b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: “I, [Covered Person’s name], authorize Arkansas Blue Cross and Blue Shield and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Arkansas Blue Cross. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review.”

- Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with the Company's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.

6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.

7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Coordinator in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.

8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:

- a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or
- b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.

9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Benefit Certificate to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).

10. **Timing of Appeal Determination.**

- a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.

- b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.

- 11. Notification of Determination of Independent Medical Review.**

- a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, your health care Provider, the Company and the Arkansas Insurance Commissioner.
 - b. **The Notification shall include.**
 - i. A general description of the reason for the request for external review;
 - ii. The date the Independent Review Organization was notified by the Company to conduct the review;
 - iii. The date the external review was conducted;
 - iv. The date of the Independent Medical Reviewer's determination;
 - v. The principal reason(s) for the determination;
 - vi. The rationale for the determination; and
 - vii. References to the evidence or documentation, including practice guidelines, considered in the determination.
12. **Expedited External Review.**
- a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.
 - b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b and 7.3.11 whether you will be required to complete the internal review process.
 - c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.
13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.
14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.
15. **Filing Fee.** You are required to pay a twenty-five dollar (\$25) fee to submit an appeal for external review. If the external review results in a reversal of the claim denial, in whole or in part, the Company will refund your filing fee. This twenty-five dollar (\$25) filing fee will be waived if (1) you have previously paid seventy-five dollars (\$75) in filing fees during the plan year or (2) paying of the fee will impose an undue financial hardship.
16. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

GLOSSARY OF TERMS, Health Interventions is hereby amended to read as follows.

Health Intervention or Intervention means an item, Medication or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Group Benefit Certificate. All other provisions remain in full force and effect.

A handwritten signature in black ink that reads "P. Mark White". The signature is written in a cursive, flowing style.

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
COMPREHENSIVE MAJOR MEDICAL
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2613
RENEWAL AMENDMENT
Form Nos. 163,164,232,233,234,235,239,240,241,242,
243,244,245,246,263,265,266,267,268,269,270,271**

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN is hereby amended to add the following new Subsection.

Autism Spectrum Disorder Benefits. Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate as well as the Deductible and Coinsurance set out in the Schedule of Benefits, coverage is provided for Covered Persons with autism spectrum disorder that is diagnosed by a licensed doctor of medicine or licensed psychologist. Further, subject to Prior Approval from the Company as well as the Deductible and Coinsurance set out in the Schedule of Benefits, coverage is provided for applied behavior analysis when provided by or supervised by a Board Certified Behavioral Analyst and provided to Covered Persons under the age of 18. [Applied behavioral analysis services have a calendar year benefit limit of fifty thousand dollars (\$50,000).] **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the applied behavior analysis meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any applied behavior analysis receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any applied behavior analysis receiving Prior Approval may still be limited or denied if, when the claims for the applied behavior analysis are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.**¹

SPECIFIC PLAN EXCLUSIONS, Miscellaneous Fees and Services, "IDEA Covered Services" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Group Benefit Certificate. All other provisions remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

¹ The sentence with the bracketed limit on ABA of \$50,000 will only apply to small groups without Mental Health Parity benefits.



**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
COMPREHENSIVE MAJOR MEDICAL
INDIVIDUAL INSURANCE POLICIES**

**AMENDMENT NO. 2614
GENERAL AMENDMENT
Form Nos. 236, 237, 238, 247, 259, 260, 262, 272, 273, 274, 275, 276**

The following subsection amendments are effective on January 1, 2012.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Therapy Services, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Emergency Care" is hereby amended to read as follows.

Emergency Care Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Emergency Care when provided in the emergency room of a Hospital. When Emergency Care is needed the Covered Person should seek care at the nearest facility. Emergency Care must be received within forty-eight (48) hours of the emergency. Emergency Care services are subject to a \$200 Copayment.

Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, the Company determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Policy (See Subsection 9.0 Emergency Care), coverage shall be subject to the Major Medical Services Deductible and Coinsurance specified in the Schedule of Benefits.^{1]}

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Emergency Care" is hereby amended to read as follows.

Emergency Care Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Emergency Care when provided in the emergency room of a Hospital. When Emergency Care is needed the Covered Person should seek care at the nearest facility. Emergency Care must be received within forty-eight (48) hours of the emergency. Emergency Care services are subject to a \$200 Copayment.

Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, the Company determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Policy (See Subsection 9.0 Emergency Care), coverage shall be subject to the Deductible and Coinsurance as stated in the Schedule of Benefits.^{2]}

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Preventive Health Services" is hereby amended to read as follows.

Preventive Health Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy (with the exception of Subsection 2.2.1), the Company will pay one hundred percent (100%) of the Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center

¹ This specific provision applies to 17-258 and 17-272 only.

² This specific provision applies to 17-247, 17-259, 17-262, 17-273, 17-275 and 17-276.

setting when the service cannot be performed in an office by a Primary Care Physician. However, for services received by Non-Preferred Provider Physicians, the Company will pay eighty percent (80%) subject to the Major Medical Services Deductible.

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.^{3]}

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Preventive Health Services" is hereby amended to read as follows.

Preventive Health Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy (with the exception of Subsection 2.2.1), the Company will pay one hundred percent (100%) of the Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician. However, for services received by Non-Preferred Provider Physicians, the Company will pay eighty percent (80%) subject to the appropriate Deductible.

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.^{4]}

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions" is hereby amended to add the following new Subsection.

Gastric Pacemaker Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy including the Deductible and Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from the Company. **Please note that Prior Approval does not guarantee payment or**

³ Only applies to 17-272.

⁴ Only applies to 17-273, 17-274, 17-275 and 17-276

assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Gastric Electrical Stimulators" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

CLAIM PROCESSING AND APPEALS, Claim Processing, "Explanation of Benefit Determination" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Documentation" Subsection b. is hereby amended to read as follows.

Appellant's Right to Information. The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

- i. were relied upon in making the benefit determination;
- ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- iii. demonstrate compliance with the terms of the Plan.; or
- iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Notification of Determination of Appeal to Plan" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review) "Claim Appeals Subject to External Review", is hereby amended to read as follows.

1. **Claim Appeals Subject to External Review.**
 - a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.
 - b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other

than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:

- i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or
- ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or
- iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or
- iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.13) and you have simultaneously submitted an appeal to the Plan.

2. **Where and When to Submit External Review Appeal.** You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling 1-800-282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.3.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.

3. **Independent Review Organization and Independent Medical Reviewer**

- a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.
- b. **The Independent Review Organization** is not affiliated with, owned by or controlled by the Company. The Company pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.
- c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an employee of the Company and does not provide services exclusively for the Company or for individuals holding insurance coverage with the Company. The Independent Medical Reviewer has no material financial, familial or professional relationship with the Company, with the Plan Administrator, with an officer or director of the Company or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.

4. **Documentation**

- a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

- b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Covered Person's name], authorize Arkansas Blue Cross and Blue Shield and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Arkansas Blue Cross. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."
- 5. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with the Company's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.
- 6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.
- 7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Coordinator in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.
- 8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:
 - a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or
 - b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.
- 9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Benefit Certificate to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).
- 10. **Timing of Appeal Determination.**
 - a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
 - b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.
- 11. **Notification of Determination of Independent Medical Review.**
 - a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written

notification of the determination to you, your health care Provider, the Company and the Arkansas Insurance Commissioner.

b. **The Notification shall include.**

- i. A general description of the reason for the request for external review;
- ii. The date the Independent Review Organization was notified by the Company to conduct the review;
- iii. The date the external review was conducted;
- iv. The date of the Independent Medical Reviewer's determination;
- v. The principal reason(s) for the determination;
- vi. The rationale for the determination; and
- vii. References to the evidence or documentation, including practice guidelines, considered in the determination.

12. **Expedited External Review.**

- a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.
- b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b and 7.3.11 whether you will be required to complete the internal review process.
- c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.

13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.

14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.

15. **Filing Fee.** You are required to pay a twenty-five dollar (\$25) fee to submit an appeal for external review. If the external review results in a reversal of the claim denial, in whole or in part, the Company will refund your filing fee. This twenty-five dollar (\$25) filing fee will be waived if (1) you have previously paid seventy-five dollars (\$75) in filing fees during the plan year or (2) paying of the fee will impose an undue financial hardship.

16. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
LITTLE ROCK, ARKANSAS 72201

**AMENDMENT NO. 2564
PREVENTIVE HEALTH SERVICES**

TABLE OF CONTENTS, is hereby amended to add the following new Subsection in 3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN.

Preventive Health Services

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Children's Preventive Services is hereby amended to read as follows.

Children's Preventive Services. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for children's preventive health care services for eligible Dependents from birth through age eighteen (18), subject to the following limitations:

1. Covered services are limited to age appropriate medical history; physical examination, including routine tests and procedures to detect abnormalities or malfunctions of bodily systems and parts; developmental assessment; anticipatory guidance, including visual evaluation, hearing evaluation, dental inspection for children under two years of age and nutritional assessment; appropriate immunizations; and laboratory tests.
2. Coverage is limited to not more than twenty (20) visits. A covered visit is one occurring during one of the following intervals: at birth; within two (2) weeks after birth; within two (2) weeks preceding or following the date the eligible Dependent reaches the following ages: two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, and eighteen (18) months; or within one (1) month preceding or following the date the eligible Dependent reaches the following ages: two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years.
3. Coverage for any visit is limited to services provided by or under the supervision of a Physician.
4. The Company will pay one hundred percent (100%) of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. However, intranasally administered influenza vaccination(s) such as Flumist are subject to the maximum benefit the Plan allows for injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Prostate Cancer Screenings is hereby deleted in its entirety. All remaining subsections are hereby renumbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Miscellaneous Health Interventions, “Adult Immunizations” and “Colorectal Cancer Examinations and Laboratory Tests” are hereby deleted in their entirety. All remaining subsections are hereby renumbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN is hereby amended to add the following new Subsection.

Preventive Health Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate (with the exception of Subsection 2.2.1), the Company will pay one hundred percent (100%) of the Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician’s assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician’s office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician. However, for services received by Non-Preferred Provider Physicians, the Company will pay eighty percent (80%) subject to the appropriate Deductible.¹

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

¹ Victoria Charlesworth discovered the need to amend this language while reviewing an appeal for preexisting conditions. We need to allow for services to be provided in an outpatient setting as mammographies and colonoscopies are not performed in an office setting. This will apply to all Preventive Health Service benefits for all lines of business – group and individual.

SPECIFIC PLAN EXCLUSIONS is hereby amended to delete Subsections “Preventive Medicine Counseling” and “Screening Test.” All remaining Subsections are renumbered to correlate with the change.

GLOSSARY OF TERMS is hereby amended to add the following new Subsection. All remaining Subsections are renumbered to correlate with the change.

Primary Care Physician means a Preferred Provider Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology or Internal Medicine. This also includes advanced practice nurses or physician’s assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician’s office.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Group Benefit Certificates. All other provisions of the Benefit Certificate remain in full force and effect.



P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

**AMENDMENT NO. 2567
PREVENTIVE HEALTH SERVICES**

TABLE OF CONTENTS, is hereby amended to add the following new Subsection in 3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN.

Preventive Health Services

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Children's Preventive Services is hereby amended to read as follows.

Children's Preventive Services. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for children's preventive health care services for eligible Dependents from birth through age eighteen (18), subject to the following limitations:

1. Covered services are limited to age appropriate medical history; physical examination, including routine tests and procedures to detect abnormalities or malfunctions of bodily systems and parts; developmental assessment; anticipatory guidance, including visual evaluation, hearing evaluation, dental inspection for children under two years of age and nutritional assessment; appropriate immunizations; and laboratory tests.
2. Coverage is limited to not more than twenty (20) visits. A covered visit is one occurring during one of the following intervals: at birth; within two (2) weeks after birth; within two (2) weeks preceding or following the date the eligible Dependent reaches the following ages: two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, and eighteen (18) months; or within one (1) month preceding or following the date the eligible Dependent reaches the following ages: two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years.
3. Coverage for any visit is limited to services provided by or under the supervision of a Physician.
4. The Company will pay one hundred percent (100%) of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. However, intranasally administered influenza vaccination(s) such as Flumist are subject to the maximum benefit the Plan allows for injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Prostate Cancer Screenings is hereby deleted in its entirety. All remaining subsections are hereby renumbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Miscellaneous Health Interventions, “Adult Immunizations” and “Colorectal Cancer Examinations and Laboratory Tests” are hereby deleted in their entirety. All remaining subsections are hereby renumbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN is hereby amended to add the following new Subsection.

Preventive Health Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate (with the exception of Subsection 2.2.1), the Company will pay one hundred percent (100%) of the Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician’s assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician’s office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician. However, for services received by Non-Contracting Provider Physicians, the Company will pay eighty percent (80%) subject to the Deductible.¹

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

¹ Victoria Charlesworth discovered the need to amend this language while reviewing an appeal for preexisting conditions. We need to allow for services to be provided in an outpatient setting as mammographies and colonoscopies are not performed in an office setting. This will apply to all Preventive Health Service benefits for all lines of business – group and individual.

SPECIFIC PLAN EXCLUSIONS is hereby amended to delete Subsections “Preventive Medicine Counseling” and “Screening Test.” All remaining Subsections are renumbered to correlate with the change.

GLOSSARY OF TERMS is hereby amended to add the following new Subsection. All remaining Subsections are renumbered to correlate with the change.

Primary Care Physician means a Contracting Provider Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology or Internal Medicine. This also includes advanced practice nurses or physician’s assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician’s office.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Group Benefit Certificates. All other provisions of the Benefit Certificate remain in full force and effect.



P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

SERFF Tracking Number: ARBB-127684374 State: Arkansas
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 49941
 Company Tracking Number: 23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Amendments
 Project Name/Number: General Amendments/23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	10/10/2011
Comments: See attached.		
Attachment: Flesch Certification Forms23-2612,23-2613,23-2613 1-12,23-2564,23-2567 R1-12.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved	10/10/2011
Bypass Reason: Not needed.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved	10/10/2011
Comments: See attached.		
Attachment: Final_PPACA_UniformComplianceSummaryGrp-2564,2567 R1-12.pdf		



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

**RE: Arkansas Blue Cross and Blue Shield
Amendment Nos. 23-2612,23-2613,23-2614 1/12,23-2564,23-2567
R1/12**

FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced documents have achieved a Flesch Reading Ease Score average of 40.7 and comply with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Disability Insurance Policy Language Simplification Act.

Name

Vice President

Title

October 4, 2011

Date

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- ☐ INDIVIDUAL HEALTH BENEFIT PLANS (Complete [SECTION A](#) only)
- ☒ SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

☒ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Arkansas Blue Cross and Blue Shield	83470		All group forms currently issued	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

[Reset Form](#)

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network. Explanation: Page Number:	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology. Explanation: Page Number:	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

[Reset Form](#)

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: See amendment number 23-2565			
	Page Number: 2			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: See amendment number 23-2565			
	Page Number: 1-2			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: See amendment number 23-2565			
	Page Number: 2			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: See amendment number 23-2565			
	Page Number: 3			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: See amendment number 23-2564 and 23-2567			
	Page Number: 1			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes [◇] <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Already filed and approved - #23-2552			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: See amendment number 23-2612			
	Page Number:			

◇ For plan years beginning before January 1, 2010, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Arkansas Blue Cross currently provides in-network coverage for all emergency services without prior authorization.			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Arkansas Blue Cross does not require designation of a PCP			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Arkansas Blue Cross does not require authorization or referral for OB/GYN services			
	Page Number:			

SERFF Tracking Number: ARBB-127684374 *State:* Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield *State Tracking Number:* 49941
Company Tracking Number: 23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: Amendments
Project Name/Number: General Amendments/23-2612,23-2613,23-2614 1/12,23-2564,23-2567 R1/12

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/04/2011	Form	Amendment	10/27/2011	23-2612 1-1-12 Filing Version.pdf (Superceded)



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
COMPREHENSIVE MAJOR MEDICAL
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2612
GENERAL AMENDMENT
Form Nos. 163,164,232,233,234,235,239,240,241,242,
243,244,245,246,263,265,266,267,268,269,270,271**

The following subsection amendments are effective on January 1, 2012.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Therapy Services, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Maternity," Subsection 3. is hereby amended to read as follows.

Newborn Care in the Hospital. Provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. An Employee or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services.^{1]}

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions" is hereby amended to add the following new Subsections.

Gastric Pacemaker Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate including the Deductible and Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from the Company. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f.** All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Benefit Certificate.

Pilot Project Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, from time to time, the Company may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Benefit Certificate, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting the Company's website at WWW.ARKANSASBLUECROSS.COM or by calling Customer Service.

¹ Will not apply to groups without maternity coverage.

SPECIFIC PLAN EXCLUSIONS, Health Care Providers is hereby amended to add the following new Subsection. All remaining Subsections are re-numbered to correlate with the change.

Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Gastric Electrical Stimulators" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

CLAIM PROCESSING AND APPEALS, Claim Processing, "Explanation of Benefit Determination" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Documentation" Subsection b. is hereby amended to read as follows.

Appellant's Right to Information. The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

- i. were relied upon in making the benefit determination;
- ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- iii. demonstrate compliance with the terms of the Plan.; or
- iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Notification of Determination of Appeal to Plan" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review) "Claim Appeals Subject to External Review", is hereby amended to read as follows.

1. **Claim Appeals Subject to External Review.**
 - a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.
 - b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:
 - i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or

- ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or
 - iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or
 - iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.13) and you have simultaneously submitted an appeal to the Plan.
- 2. **Where and When to Submit External Review Appeal.** You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling 1-800-282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.3.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.
- 3. **Independent Review Organization and Independent Medical Reviewer**
 - a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.
 - b. **The Independent Review Organization** is not affiliated with, owned by or controlled by the Company. The Company pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.
 - c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an employee of the Company and does not provide services exclusively for the Company or for individuals holding insurance coverage with the Company. The Independent Medical Reviewer has no material financial, familial or professional relationship with the Company, with the Plan Administrator, with an officer or director of the Company or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.
- 4. **Documentation**
 - a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
 - b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Covered Person's name], authorize Arkansas Blue Cross and Blue Shield and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Arkansas Blue Cross. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."

5. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with the Company's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.
6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.
7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Coordinator in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.
8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:
 - a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or
 - b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.
9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Benefit Certificate to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).
10. **Timing of Appeal Determination.**
 - a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
 - b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.
11. **Notification of Determination of Independent Medical Review.**
 - a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, your health care Provider, the Company and the Arkansas Insurance Commissioner.
 - b. **The Notification shall include.**
 - i. A general description of the reason for the request for external review;
 - ii. The date the Independent Review Organization was notified by the Company to conduct the review;
 - iii. The date the external review was conducted;
 - iv. The date of the Independent Medical Reviewer's determination;

- v. The principal reason(s) for the determination;
 - vi. The rationale for the determination; and
 - vii. References to the evidence or documentation, including practice guidelines, considered in the determination.
12. **Expedited External Review.**
- a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.
 - b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b and 7.3.11 whether you will be required to complete the internal review process.
 - c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.
13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.
14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.
15. **Filing Fee.** You are required to pay a twenty-five dollar (\$25) fee to submit an appeal for external review. If the external review results in a reversal of the claim denial, in whole or in part, the Company will refund your filing fee. This twenty-five dollar (\$25) filing fee will be waived if (1) you have previously paid seventy-five dollars (\$75) in filing fees during the plan year or (2) paying of the fee will impose an undue financial hardship.
16. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Group Benefit Certificate. All other provisions remain in full force and effect.



P. Mark White, President and Chief Executive Officer

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